

# Assessing the Need for Hospitalization in Order to Conduct a Psychiatric Evaluation as part of Criminal Law Procedure

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**ABSTRACT:** **Background:** In criminal law, psychiatrists are consulted regarding the “insanity defense” and the defendant’s competency to stand trial. Court-ordered hospital admissions for such evaluations are on the increase, creating a major burden on the health system.

**Objectives:** To assess, in a hospital setting, whether hospitalization of the defendant is necessary for conducting a psychiatric evaluation.

**Methods:** A 6 month prospective observational study exploring the phenomenon was conducted at the Beer Yaakov Mental Health Center. The psychiatrist was asked both at the initiation and at the end of the assessment process whether the subject was competent to stand trial and responsible for his/her actions and if hospitalization was necessary in order to conduct the evaluation.

**Results:** During the study period there were 112 admissions with a court request for a psychiatric evaluation. In 73 of the cases (65.2%) the evaluating psychiatrist believed there was no need for hospitalization. This assessment did not change by the end of the hospitalization in all cases. Employment and alcohol use were the only factors associated with a lower need for hospitalization (OR 0.24, 95%CI 0.07–0.77, and OR 0.34, 95%CI 0.13–0.90, respectively).

**Conclusions:** In the majority of cases, based on the evaluating psychiatrist’s responses, the evaluation could have been conducted without need for hospitalization. The findings indicate that an outpatient unit designated to write court-requested psychiatric evaluations could significantly reduce the rates of hospital admissions for this purpose.

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**KEY WORDS:** criminal law, psychiatric evaluation, competency, criminal responsibility, hospitalization

In criminal law, psychiatrists are consulted about two main issues: the “insanity defense” and the defendant’s competency to stand trial. The insanity defense is utilized when the defendant is found to be not responsible for his or her actions

due to mental health problems. The second issue addressed by psychiatrists in forensic law is competency to stand trial. Competency is defined as the ability of a defendant to understand and rationally participate in a court process. Whenever evidence exists that the defendant’s competency may be compromised, the court is obligated to assess competency in order to continue with a trial. In Israel, the court’s decision to refer a person for psychiatric evaluation was defined in the Mental Health Treatment act (1991). Many defendants in criminal law who are referred for psychiatric evaluation are sent to a psychiatric hospital where the observation and evaluation are carried out. A number of sections in the Israeli Mental Health Treatment act relate to this procedure. Section 15 of the law states that the court cannot make a decision on the defendant’s competency to stand trial or the insanity defense, unless the court receives a psychiatric evaluation on these issues. In order to obtain such an evaluation, the court must order that the defendant undergo a psychiatric evaluation. If the district psychiatrist decides that the evaluation can take place only if the defendant is an inpatient in a psychiatric hospital, the court can order that the subject be hospitalized for evaluation and examination for a period of time that will be determined by the court. The number of evaluations on competency to stand trial appears to be growing incrementally [1]. In the year 2000 the estimated number of these evaluations in the United States was approximately 60,000 [2]. Three decades ago Winick [3] estimated that over \$185 million was spent in the USA annually for competency evaluations. A decade later he suggested that this number may be closer to double or triple the initial estimate [4]. With the passing of another two decades it is likely that this number is even larger.

Over the last decade, court-ordered hospitalizations for evaluation have also increased in Israel. In the years 2009–2011, compulsory admissions for court-ordered evaluations constituted an average 6.3% of all psychiatric hospital admissions in Israel [5]. The absolute number of court-ordered hospitalizations doubled during the years 2004–2013 (unpublished data). Miller [6] described a number of successful pilot

studies in the U.S. aimed at reducing the number of referrals to inpatient evaluation by referring them to community-based evaluations. Zapf and Ronald [7] described an attempt to limit inpatient evaluations to a period of 5 days as defined by the criminal code, but in practice these evaluations continued to be extended for longer periods, in one study averaging 23 days. Different screening tools have been created to prevent lengthy inpatient evaluations, but as of 1996, Roesch et al. [8] reported that in Canada 88% of court orders for evaluation were still being referred to inpatient services. Lengthy hospitalizations occupy much needed hospital beds, take up the time and attention of a large number of hospital personnel, and pose a major financial burden due to the cost of hospitalization.

An additional issue relates to ethical aspects of the inpatient evaluation. Most evaluations are conducted in closed wards, thus depriving individuals of their right to liberty and sometimes leading to unnecessary pain and suffering due to unnecessary hospitalization. In view of the major drawbacks of the existing system – the increased burden on psychiatric hospitals, the higher financial costs, and the aforementioned limited basic human rights for liberty – the present study explores whether inpatient hospitalization is necessary to conduct a psychiatric court evaluation. The aim of our study was to assess the rate of actual need for inpatient observations as compared to short-term evaluations that could potentially be carried out in an outpatient framework. To the best of our knowledge, the present study is the first attempting to assess this issue.

## SUBJECTS AND METHODS

The study was an observational study conducted in four acute psychiatric units at the Beer Yaakov Mental Health Center. The study was approved by the local Institutional Review Board. Inclusion criteria were age 18 and above, and hospitalization in the acute units under court order for observation. After a subject was received under court order and had been assessed by a senior psychiatrist in the ward, the psychiatrist was asked to state his/her opinion on the following: (i) Is the subject competent to stand trial? (ii) Is the subject responsible for his/her actions? (iii) Is hospitalization necessary to carry out the court-requested evaluation? Following the assessment and period of hospitalization, the assessing psychiatrist was asked the same questions. Cases where the court-requested assessment could have been conducted without hospitalization were defined as those where the assessing psychiatrist decided there was no need for hospitalization both at the initiation and at the end of the assessment process, and where there was no change in the answers to questions of competency and responsibility between the beginning and end of the assessment. Demographic, legal and medical information was gathered from the records.

## STATISTICAL ANALYSIS

We examined the associations between the demographic variables, clinical and legal characteristics and the outcome measure: the need for hospitalization in order to conduct a psychiatric evaluation. Two variable relationships were examined by chi-square tests. Variables that had significant relationships with any of the parameters entered a multivariate model based on logistic regression. Relationship with the outcome measure was examined while neutralizing the interplay between the predictors. The results were obtained in terms of odds ratio (OR) and confidence interval (95%CI). Processing was carried out using SPSS software (IBM Inc.), Version 20.0.

## RESULTS

The study was conducted over 6 months (April to October 2012). During the study period there were 112 admissions to the four acute hospital psychiatric units with a court request for a psychiatric evaluation. In 73 of the cases (65.2%) the psychiatrist believed that evaluation did not require that the defendant be hospitalized. The average length of stay (LOS) for these cases was 5 days, leading to a total of 363 hospitalization days. In the remaining 39 cases (34.8%) the psychiatrist assessed that there was need for hospitalization. In these cases LOS was 10 days on average, 393 days in total. In 83% of cases competency to stand trial and criminal responsibility could be determined after the first psychiatric examination on the ward. In 20 cases the need for hospitalization was due to the subject's clinical mental state, and in 19 of the cases, after the initial assessment, the question of legal responsibility or competency remained unanswered and required further evaluation. In 13 of those cases both competency and responsibility remained undetermined following the initial evaluation, in 2 cases competency issues remained undetermined, and in 4 cases responsibility issues remained undecided. With regard to the need for hospitalization, in all cases there was no difference between the assessment by the evaluating psychiatrist upon receiving the patient compared to a repeat assessment at the end of the hospitalization. Eighty-four subjects (75%) were considered competent to stand trial and responsible for their actions. Twenty-five patients (23.3%) were found not competent and/or not responsible. In all cases where a conclusion regarding responsibility or competency was reached after the initial examination on the ward, the decision remained unchanged at the completion of the hospitalization period. Conclusions regarding the issue of competency and responsibility in the first examination and at the end of hospitalization are summarized in Table 1.

Mean age was  $34.5 \pm 12.2$  years (range 18–64) and 97 were males (86.6%). About half the females (53%) were assessed as requiring hospitalization compared to 33% of males – a difference that did not reach statistical significance ( $P = 0.13$ ).

**Table 1.** Responsibility and competence evaluation conclusion

	Conclusion after initial assessment		Conclusion at termination of hospitalization period	
	Responsibility	Competence	Responsibility	Competence
Yes	74	80	84	91
No	17	17	22	21
Unknown	17	15	2	0
Not relevant	4	0	4	0
Total	112	112	112	112

Twenty subjects (18%) were married and 27 were employed (24%). Regarding demographics, the only significant difference associated with need for hospitalization was employment: working subjects had lower rates of hospitalization need (OR 0.24, 95%CI 0.07–0.77,  $P < 0.01$ ).

A total of 102 subjects were referred to hospitalization for evaluation while under arrest, of whom only 33% were assessed to require hospitalization for the evaluation. Ten were not in custody, including 6 who were deemed in need of hospitalization. Previous psychiatric diagnostic details are presented in Table 2. Despite not finding statistically significant findings associating the need for hospitalization with prior psychiatric diagnosis, several prominent findings were noted. Among cases of a prior psychotic state, without a diagnosis of personality disorder or substance abuse disorder, the majority needed hospitalization (17 of 32). In all the cases with a prior psychotic state, including those diagnosed with a personality disorder or substance use disorder, the need for hospitalization was 43%. In all other diagnoses, rates of need for hospitalization were lower, with similar rates for cases with no prior psychotic state (27%) and cases with no previous psychiatric diagnosis (29%). Diagnoses in which the rates of need for hospitalization were especially low (lower even than cases with no previous psychiatric diagnosis) included substance-related disorder (with no previous psychotic state) in 9% (1 of 11) and mental retardation in 20% (1 of 5, where the need for hospitalization was due to lack of cooperation).

No correlation was found between past psychiatric hospitalization not related to court evaluation, past ambulatory psychiatric treatment, and the need for hospitalization to conduct the evaluation. In 48 cases a court-mandated psychiatric evaluation had been carried out in a previous legal procedure regarding the question of responsibility or competency. In 20 cases the subject was previously found to be incompetent or not responsible. Previous conclusions relating to competency and responsibility did not correlate with need for hospitalization. Among the 112 subjects, present substance use for alcohol and illicit drugs was 37% and 42%, respectively. An additional 10% reported past usage of alcohol and 19% reported past use of drugs with no present use.

**Table 2.** Previous psychiatric diagnosis details

Prior psychiatric diagnosis	Total (n=112)	Need for hospitalization (n=39)	No need for hospitalization (n=73)
Psychosis*	51	22	29
Psychosis with no substance abuse or personality disorder	32	17	15
Psychosis with substance abuse	15	3	12
Psychosis with personality disorder	11	4	7
Substance use disorder	26	4	22
Substance use disorder with no psychosis	11	1	10
Personality disorder	23	7	16
Personality disorder with no psychosis	12	3	9
Organic brain disorder	2	2	0
Mental retardation (mild)	5	1	4
Other disorders**	10	2	8
No psychosis	61	17	44
No diagnosis	34	10	24

\*Schizophrenia/schizoaffective disorder n=44, delusional disorder n=2 (both cases needed hospitalization), psychotic episode (not related to substance abuse) n=2, bipolar affective disorder type 1 n=3

\*\*Anxiety, depression, post-traumatic stress disorder, somatoform disorder, behavior-related disorder

Consumption of alcohol was unknown in 29% and of drugs unknown in 14%. There was less need for hospitalization with alcohol use, when present or past alcohol use was found to be significant negative predictors for hospitalization need (OR 0.34, 95%CI 0.13–0.90). Of those with no known alcohol use, 51.9% needed hospitalization as compared to current or past users (26.8% and 27.3% respectively,  $P = 0.038$ ). No correlation was found between past or present illicit drug abuse and the need for hospitalization. Only 20% of those with a previous conviction were found to require hospitalization. This rate is significantly lower than in subjects with no criminal record (41%) or subjects with prior arrests yet no prior convictions (56%), previously  $< 0.01$ .

There was a large number and variety of criminal charges. In most cases there was more than one criminal charge, with many combinations. The most common criminal charges included threats (64, 57%), damage to property (40, 36%), violence (33, 29%), offences against police (20, 18%), and property crimes (theft) (13, 12%). There were high rates of hospitalization need among those charged with violence (57.9%) and damage to property (60%) ( $P = 0.053$ ). We did not find a correlation between characteristics of the victim of the offense (stranger/acquaintance/family member/close family member) and need for hospitalization.

### TREATMENT RECOMMENDATIONS IN THE PSYCHIATRIC EVALUATION

At the completion of the evaluations, forced psychiatric treatment with hospitalization was recommended in 19 cases (17%). Forced ambulatory treatment was recommended in four cases. For those found to be competent and responsible (n=87), voluntary ambulatory treatment was recommended in 39 cases, and treatment by other services (social or rehabilitation services) for 4 of them. For six subjects it was recommended that treatment be provided solely by other services.

### DISCUSSION

Our study relates to cases of court-mandated psychiatric evaluation for subjects referred to an inpatient-based evaluation. Study results show that in most cases the evaluating psychiatrist found that the assessment could have been carried out without hospitalization. Remarkably, in all these cases, the psychiatrist's assessment had not changed by the end of the hospitalization period. It is clear that deciding on the need for hospitalization for court-mandated psychiatric evaluation regarding competency and responsibility cannot be based solely on past information, however relevant it may seem. Determining competency and responsibility – as with diagnostic questions – is based on a combination of past information with the present clinical evaluation, the nature of the crime, the manner of the crime execution, and the motive. In some cases there may even be a need for psycho-diagnostic or neuropsychological testing.

Most of the demographic, medical and legal information gathered did not seem to function as significant correlating factors when assessing the need for hospitalization for a court-mandated evaluation. Employment and alcohol use were the only factors significantly associated with a low need for hospitalization. Employment is a significant indicator regarding a person's ability for sound judgment and the potential to act according to a set of rules. Therefore, the probability that a working person will be found to be not competent or not responsible for their actions is low, and in most of these cases it was deemed that there was no need for hospitalization to carry out the evaluation. Alcohol is a well-established cause for verbal and behavioral disinhibition [9]. Behavior under the influence of alcohol may be interpreted as “not sane” and result in a court request for a psychiatric evaluation. In most cases, an experienced clinician can confidently differentiate whether an action was carried out under the influence of alcohol as opposed to a psychotic state, and there would be no need for hospitalization.

A significant negative correlation was noted between past criminal conviction and need for hospitalization evaluation. This is not surprising since recidivism of criminal activity can be expected in convicted offenders. In addition, the need for hospitalization tended to be higher among people with a current charge of violence and threat offenses, as opposed to sex, drug and “white collar” offenses where the need for

hospitalization was lower (with no statistical significance in the latter cases, probably due to the small number of cases). No statistical significance was found when comparing need for hospitalization and past psychiatric diagnosis. This may be due to the large number of diagnostic possibilities, which limits the possibility of reaching statistical significance. However, it is important to note that rates of need for hospitalization were higher in those with a past psychosis diagnosis as compared to past non-psychosis diagnoses. Moreover, in subjects with past non-psychosis diagnoses, the rate of need for hospitalization was similar or lower as compared to subjects with no previous psychiatric diagnosis. An adult who was previously diagnosed and treated for a mental condition, and who was not found to be suffering from a psychotic disorder, has a higher likelihood of being considered competent and responsible, as compared to those who have no psychiatric background. This is true also when relating to need for hospitalization. Therefore, when a decision is made to refer a person for psychiatric evaluation to hospitalization, based on past psychiatric treatment, a number of factors should be considered: a past psychosis diagnosis, previous treatment with antipsychotic medication, and whether previous psychiatric hospitalizations were for the purpose of treatment or a court-mandated evaluation. In cases where a court-mandated evaluation was carried out, the conclusions of that evaluation should be noted.

A limitation of our study is that it included only subjects who were hospitalized for evaluation. Therefore, evaluations carried out in an outpatient setting were excluded. Future studies may want to include these evaluations for comparison. The district psychiatrist is not capable of carrying out all the court-requested evaluations in the district within the short time frame allotted by the court for this purpose. Therefore, subjects are referred to the most convenient place for these evaluations – the psychiatric inpatient unit. In practice, the vast majority of subjects who are referred by the court for evaluation in a hospital setting are under arrest. In these cases, the court-ordered evaluation must be submitted to the court within a short time, generally within a few days to a week. Writing a court-mandated psychiatric evaluation cannot be hasty and necessitates the utmost care. In many cases it is necessary to interview relatives of the defendant, and there may be need for other evaluations [10]. None of these can be performed in the emergency room, yet additional tests do not necessarily indicate that there is a need for hospitalization. We propose that an outpatient psychiatric unit designated for writing court-requested psychiatric evaluations for detainees, in the shortest possible period of time, could significantly reduce the rates of hospital admissions for this purpose. If necessary, the examining psychiatrist could summon the subject from custody for further assessment. In cases where the evaluating psychiatrist believes there is a need for further in-depth psychiatric evaluation, including continuous observation of behavior, the subject

will be referred to hospitalization in a psychiatric ward for the court-requested evaluation. In cases where the evaluating psychiatrist finds there is immediate need for hospitalization due to the subject's mental state, he can write the evaluation and concurrently refer the subject for hospitalization.

An outpatient psychiatric unit designated for writing court-requested psychiatric evaluations would contribute significantly to reducing the number of court referrals for inpatient evaluations, and have substantial financial, ethical and clinical implications. Further investigation would be mandated to clarify the nature of the role of these specialized forensic units.

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### References

- Roesch R, Zapf PA, Golding SL, Skeem J. Defining and assessing competency to stand trial. In: Weiner IB, Hess AK, eds. *Handbook of Forensic Psychology*. 2<sup>nd</sup> edn. New York: John Wiley and Sons, 1999: 327-49.
- Bonnie RJ, Grisso T. Adjudicative competence and youthful offenders. In: Grisso T, Schwartz RG, eds. *Youth on Trial: A Developmental Perspective on Juvenile Justice*. Chicago: University of Chicago Press, 2000: 73-103.
- Winick BJ. Restructuring competency to stand trial. *UCLA Law Rev* 1985; 32: 921-85.
- Winick BJ. Incompetency to proceed in the criminal process: past, present, and future. In Wexler DB, Winick BJ, eds. *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*. Durham, NC: Carolina Academic Press, 1996: 77-111.
- Statistical annual. Israel Ministry of Health, Department of Mental Health, 2012.
- Miller RD. Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: clinical and legal issues. *Behav Sci Law* 2003; 21.3: 369-91.
- Zapf PA, Ronald R. Assessing fitness to stand trial: a comparison of institution-based evaluations and a brief screening interview. *Can J Commun Ment Health* 1997; 16: 53-66.
- Roesch R, Hart SD, Zapf PA. Conceptualizing and assessing competency to stand trial: implications and applications of the MacArthur Treatment Competence Model. *Psychol Public Policy Law* 1996; 21: 96-113.
- Källmén H, Gustafson R. Alcohol and disinhibition. *Eur Addict Res* 1998; 4 (4): 150-62.
- Rogers R, Johansson-Love J. Evaluating competency to stand trial with evidence-based practice. *J Am Acad Psychiatry Law* 2009; 37 (4): 450-60.